Form 330 ADM (CC) (6-87)

State of New York
COMMISSION OF CORRECTION
Office of Mental Health

SUICIDE PREVENTION SCREENING GUIDELINES

DETAINEE'S NAME	SEX	DATE OF BIRTH	MOST SERIOUS CHARGE(S)	DATE	TIME

NAME OF FACILITY	NAME OF SCREENING OFFICER	*Detainee showed serious psychiatric problems during prior incarceration* Yes____ No____

Check appropriate column for each question

	Column A YES	Column B NO	General Comments/Observations
OBSERVATIONS OF TRANSPORTING OFFICER			
1. Arresting or transporting officer believes that detainee may be a suicide risk. *If YES, notify Shift Commander.*			
PERSONAL DATA	No Family/ Friends		
2. Detainee lacks close family or friends in the community.			
3. Detainee has experienced a significant loss within the last six months (e.g. loss of job, loss of relationship, death of close family member).			
4. Detainee is very worried about major problems other than legal situation (e.g., serious financial or family problems, a medical condition or fear of losing job).			
5. Detainee's family or significant other (spouse, parent, close friend, lover) has attempted or committed suicide.			
6. Detainee has psychiatric history. *(Note current psychotropic medications and name of most recent treatment agency.)*			
7. Detainee has history of drug or alcohol abuse.			
8. Detainee holds position of respect in community (e.g., professional, public official) and/or alleged crime is shocking in nature. *If YES, notify Shift Commander.*			
9. Detainee is thinking about killing himself. *If YES, notify Shift Commander.*			
10. Detainee has previous suicide attempt. *(Check wrists and note method.)*			
11. Detainee feels that there is nothing to look forward to in the future. (expresses feelings of helplessness or hopelessness). *If YES, to 10 and 11, notify Shift Commander.*			
BEHAVIOR/APPEARANCE			
12. Detainee shows signs of depression (e.g., crying, emotional flatness).			
13. Detainee appears overly anxious, afraid or angry.			
14. Detainee appears to feel unusually embarrassed or ashamed.			
15. Detainee is acting and/or talking in a strange manner (e.g., cannot focus attention, hearing or seeing things which are not there).			
16. A. Detainee is apparently under the influence of alcohol or drugs.			
B. If YES, is detainee incoherent, or showing signs of withdrawal or mental illness? *If YES to both A & B, notify Shift Commander.*			
CRIMINAL HISTORY			
17. This is detainees first arrest.			

ACTION

TOTAL Column A _____

If total checks in Column A are 8 or more, notify Shift Commander.

Shift Commander notified: Yes _____ No _____

Supervision Instituted: Routine _____ Active _____ Constant _____

Detainee Referred to Medical/Mental Health:

Yes _____ No _____

If Yes:

	EMERGENCY	NON-EMERGENCY
medical	_____	_____
mental health	_____	_____

Medical/Mental Health Personnel Actions: (To be completed by medical/MH staff)

Law & Justice Interim Committee
September 9, 2011

Exhibit 15

INSTRUCTIONS FOR COMPLETING
SUICIDE PREVENTION SCREENING GUIDELINES—FORM 330 ADM

GENERAL INFORMATION

This form is to be completed in triplicate for all detainees prior to cell assignment.

Insert top copy in detainee's file. If detainee is referred, give second copy to medical or mental health personnel. The third copy is available for use according to our facility's procedures.

Comment Column:	Use to note: 1. information about the detainee that officer feels is relevant and important. 2. information requested in questions 6 and 10, and 3. information regarding detainee's refusal or inability to answer questions (See Below - General Instructions)
Detainee's Name:	Enter detainee's first and last name and middle initial.
Sex:	Enter male (m) or female (f).
Date of Birth:	Enter day, month and year.
Most Serious Change(s):	Enter the most serious charge or charges [no more than two (2)] from this arrest.
Date:	Enter day, month and year that form was completed.
Time:	Enter the time of day the form was completed.
Name of Facility:	Enter name of jail or lock-up.
Name of Screening Officer:	Enter name of officer completing form.
Psychiatric Problems During Prior Incarceration:	The screening officer should check facility files to determine if the inmate had attempted suicide or was referred for mental health services during prior incarceration. **NOTE: Persons with a diagnosis of schizophrenia or major depression should be referred immediately to mental health as they are generally more at risk for suicide than persons with other psychiatric disorders.**

INSTRUCTIONS FOR ITEMS 1 – 17

General Instructions

Check the appropriate YES or NO box for items 1 -17.

If information required to complete these questions is unknown to screening officer, such information should be obtained by asking detainee to answer questions. However, detainee has a right to refuse to answer.

If detainee refuses to answer questions 2-11, enter RTA (refused to answer) in the Comment Column next to each question. In addition complete the YES or NO boxes only if information is known to you.

If during an otherwise cooperative interview, detainee refuses to answer one or two questions: Check YES in the box(es) next to the unanswered question(s) and enter RTA in the comment box next to each unanswered question.

If detainee is unable to answer all question 2-11, enter UTA (unable to answer) in the Comment Column next to each question. Also enter reason (e.g., rated, not English speaking) for not answering these questions in the Comment Column next to question 2. In addition complete the YES or NO boxes only if information is known to you.

Observation of Transporting Officer

ITEM (1) Suicide risk: Check YES or NO box based upon the verbal report of the arresting/transporting officer or upon the screening form completed by the police agency. If YES, notify shift commander, **NOTE: The following questions and observations should not be read word-for word but restated in your own words.**

Personal Data Questions

ITEM (2) Family/friends: Check NO box if somone other than a lawyer or bondsman would (1) be willing to post detainee's bail, (2) visit detainee while he/she is incarcerated, or (3) accept a collect call from detainee.

ITEM (3) Significant loss: Ask all three components to this question—loss of job, loss of relationship and death of close friend or family member.

ITEM (4) Worried about problems: Ask about such problems as financial, medical condition or fear of losing job. Check YES if detainee answers YES to any of these.

ITEM (5) Family/significant other attempted suicide: Significant other is defined as someone who has an important emotional relationship with the detainee.

ITEM (6) Psychiatric History: Check YES box if detainee (1) has ever had psychiatric hospitalization, (2) is currently on psychotropic medication, or (3) has been an outpatient psychotherapy during the past six months. Note current psychotropic medication and name of the most recent treatment agency in the Comment Column.

ITEM (7) Drug or Alcohol History: Check YES box if detainee has had prior treatent for alcohol/drug abuse or if prior arrests were alcohol/drug related.

ITEM (8) **Respect and shocking crime: Check YES if detainee is ashamed of arrest/detention or feels that these events cause humiliation to significant others.**

ITEM (9) Suicidal: Check YES box if detainee makes a suicidal statement or if he responds YES to direct question, "Are you thinking about killing yourself?" If YES, notify shift commander.

ITEM (10) Pevious attempt: Check YES box if detainee states he has attempted suicide. If YES, note the method used in the Comment Column. If either YES or NO, check detainee's wrists and note any scars in Comment Column.

ITEM (11) Hopeless: Check YES box if detainee states feeling hopeless, that he has given up, that he feels helpless to make his life better. If YES to both items 10 and 11, notify shift commander.

Behavior/Appearance Observations

YES or NO must always be checked for each of these items. **They are observations made by the screening officer. They are not questions.**

ITEM (12) Depression includes behavior such as: crying, emotional flatness, apathy, lethargy, extreme sadness, unusually slow reactions.

ITEM (13) Overly anxious, afraid or angry includes such behaviors as: handwringing, pacing, excessive fidgeting, profuse sweating, cursing, physical violence, threatening, etc.

ITEM (14) Unusually embarrassed or ashamed: Check YES box if detainee makes non-elicited statements indicating worry about how family/friends/community will respond to his detention.

ITEM (15) Acting in strange manner: Check YES box if you observe any unusual behavior or speech, such as hallucinations, severe mood swings, disorientation, withdrawal, etc. **If inmate is hearing voices telling him to harm himself, you should make an immediate referral to mental health services.**

ITEM (16A) Detainee under the influence: Check YES if somone is apparently intoxicated on drugs or alcohol.

ITEM (16B) Incoherence, withdrawal, or mental illness: Withdrawal means physical withdrawal from substance. If YES to both A & B, notify shift commander.

Criminal History

ITEM (17) First arrest: Check YES box if this is detainee's first detention.

SCORING

Be sure to count all checks in column A and enter total in the space provided. Notify shift commander 1) total is 8 or more, or 2) any shaded boxes are checked, or 3) if you feel notification is appropriate.

DISPOSITION

Officer Actions

Shift commander notified: Check YES or NO. Shift Commander should be notified about detainee prior to cell assignment.

Supervision instituted: Check appropriate supervisiog disposition. This section is to be completed by shift commander. For definition of active, constant and routine see N.Y.S. Commission of Correction Minimum Standards for Local Correctional Facilities.

Detainee referred to medical and mental health personnel: Check YES or NO. If YES, check emergency/nonemergency, medical/mental health. This section is to be completed by shift commander.

Medical/Mental Health Actions

This section should be completed by medical/mental health staff and should include recommendations and/or actions taken.

MENTAL HEALTH EVALUATION RECOMMENDATION

To be completed by officer or jailer and professional mental health evaluator.
Officer or jailer and a mental health professional must sign this recommendation.

PATIENT'S NAME _____

DATE & TIME WHEN PROFESSIONAL WAS CALLED _____

NAME OF PERSON MAKING CALL TO PROFESSIONAL _____

NAME OF PROFESSIONAL CONTACTED _____

PRE-EVALUATION BY OFFICER (based on initial contact with mental health professional):

Recommendation by professional as to least restrictive setting necessary to assure patient's safety (see back for post-evaluation findings):

_____ RELEASE
_____ PC CELL
_____ TRANSFER TO OUTSIDE FACILITY
_____ IN POPULATION WITH WATCH
_____ IN POPULATION, NO WATCH

OFFICER'S STATEMENT (reason for detention and evaluation): _____

_____

_____

_____

_____

_____

_____

_____

_____

SIGNATURE OF OFFICER _____ DATE _____ TIME _____

SIGNATURE OF JAILER _____ DATE _____ TIME _____

CR NUMBER _____

(OVER)

NAME OF PROFESSIONAL MAKING EVALUATION_____

DATE & TIME OF INTERVIEW BY PROFESSIONAL_____

POST-EVALUATION BY PROFESSIONAL:

Recommendation by professional regarding patient disposition:

_____ RELEASE
_____ PC CELL
_____ TRANSFER TO OUTSIDE FACILITY
_____ IN POPULATION WITH WATCH
_____ IN POPULATION, NO WATCH

EVALUATOR'S FINDINGS:_____

_____ _____ _____

SIGNATURE OF PROFESSIONAL EVALUATOR DATE TIME

BUTTE-SILVER BOW COUNTY DETENTION FACILITY

Initial Classification

This instrument is intended to aid in the initial decision of temporary cell assignment and appropriate supervision levels at booking. It requires a direct interview between the inmate and booking officer combined with specific observations.

Inmate Name: _____ Booking #: _____

ID #: _____ Sex: _____ DOB: _____ Age: _____

Screener Name: _____ Date: _____

Do you/have you use(d) any other names? _____

Current Address: _____ How Long: _____

Charge(s): _____

Highest Grade Achieved: 3 4 5 6 7 8 9 10 11 12 GED 1 2 3 4 + _____

Elementary/High School College

Can you read and write? _____

Do you have a job/were you a student before you entered the facility? Yes No

How long have you been employed/attending school? _____

Do you have any health problems? _____

_____

Do you have trouble walking up or down stairs? _____

Do you have problems being around a large group of people? _____

Are you suicidal? Yes No Have you ever tried suicide? Yes No

When was your last attempt? _____

Why did you attempt suicide? _____

Have you had any recent stressful experience (i.e. loss of a loved one, divorce, loss of job, major health problems, serious financial problems, etc.)? _____

_____

Have you ever been diagnosed as having depression, manic, bi-polar, anxiety? _____

_____

Have you ever been to the mental health center, deac psych, Warm Springs, etc.? _____

_____

Why were you there? _____

_____

Are you a member of any gang or radical group? _____

_____

Do you drink alcohol? _____ How often? _____

Do you use drugs? _____ How often? _____

What kind? _____

This section is intended to structure and document the Booking Officer's observations. These observations should be used in conjunction with the Suicide Risk Section.

	Yes	No			Yes	No			Yes	No	
1.	☐	☐	Understands Questions	9.	☐	☐	Bizarre Behavior	18.	☐	☐	Incoherent/Withdrawn
2.	☐	☐	Assaultive/Violent Behavior	10.	☐	☐	Seeing Visions	19.	☐	☐	Blank Stare
3.	☐	☐	Angry/Hostile Behavior	11.	☐	☐	Hearing Voices	20.	☐	☐	Passive/Non-Talkative
4.	☐	☐	Loud/Obnoxious Behavior	12.	☐	☐	Walks w/Stagger	21.	☐	☐	Depressed
5.	☐	☐	Unusual Suspiciousness	13.	☐	☐	Needle Marks	22.	☐	☐	Confused
6.	☐	☐	Lifeless Reaction	14.	☐	☐	Talks w/Slur	23.	☐	☐	Timid/Shy
7.	☐	☐	Eyes Red or Bloodshot	15.	☐	☐	Odor of Alcohol	24.	☐	☐	Unusually Embarrassed
8.	☐	☐	Self-Inflicted Injury Scars on Wrists, Legs, Neck	16.	☐	☐	Uncooperative	25.	☐	☐	Effeminate (if male)
				17.	☐	☐	Anxious/Afraid	26.	☐	☐	Homosexual (in appearance)

SOCIAL STRESS/SUICIDE RISK QUESTIONNAIRE

This section is intended to aid in identifying the potentially suicidal inmate and in minimizing the jail and jail staff's potential liability. Depression is the best single indicator of risk; however, also look for these symptoms: sadness and crying; withdrawal; silence; loss or gain in appetite; insomnia; mood variations; and lethargy.

Have you recently experienced any of the following? Please circle.

Job Loss	Yes	No	Marital Separation	Yes	No	Major Financial Loss	Yes	No
Arrest of a Loved One	Yes	No	Divorce	Yes	No	Other Major Problems	Yes	No
Death of a Loved One	Yes	No	Loss of Business					

Comments: _____

_____

Yes	No	Does detainee hold position of respect or prominence in the community or is the offense shocking in nature?
Yes	No	Is this the detainee's first arrest?
Yes	No	Do you have any unusual home or family problems we should know about? List: _____
Yes	No	Have you ever been in a mental health institution or had psychiatric care? List: _____
Yes	No	Have you ever attempted or contemplated suicide?
		When? _____ Where? _____
Yes	No	Are you now contemplating suicide?
Yes	No	Does the inmate's behavior suggest a risk of suicide?

Known Enemies: **Cell #**

_____

_____

_____

Co-Defendants: **Cell #**

_____

_____

_____

Arresting Officer Comments: _____

_____

_____

Booking Officer Comments: _____

_____

_____

Housing Assignment/Cell #: Holding _____ Detoxification _____ Other_____

Level of Supervision: Constant _____ 15 Minutes _____ 30 Minutes _____ Other: _____

Name of Booking Officer (Print): _____

Date: _____ Time: _____

Have you ever been convicted of a felony? _____

_____

Do you know of anyone at the facility with whom you may have problems? _____

_____

Have you read and understood the rules and regulations of the facility? Yes No

Date: _____

If you are not satisfied with your classification, you are able to appeal this. The process for the appeal is to send a request to the "Classification Supervisor" detailing your reason for the re-classification request. Do you understand this process? _____

Recommendations and Comments: _____

_____

_____

_____

_____

P.R.E.A. of 2003

SEXUAL ASSAULT AWARENESS: This document is required to be posted in each Housing Unit.

Definitions: Inmate-on- Inmate Sexual Abuse/Assault: One or more inmate engaging in, or attempting to engage in a sexual act with another inmate or the use of threats, intimidation, inappropriate touching or other actions, or communication by inmate's] aimed at coercing and or/pressuring another inmate to engage in a sexual act.

BUTTE DETENTION CENTER

These questions are mandatory!

Question to ask inmates after: they are sentenced to any of the Department of Correction's (DOC) programs: [Watch, Start, sanction to days], or have received a bond reduction hearing, have had a visit from an attorney, family member, girl friend/wife, Probation/Parole, or had a child custody hearing/visit. These questions are meant to ascertain the mental health state of the inmate, and any intervention that we need to provide.

1. Is everything ok?
2. Do you need anything, someone to talk to [family, staff, clergy]
3. Do you need some time before going back to your pod? [Place in rec room]
4. Are you feeling like you may want to hurt yourself or someone else? If yes explain.

If inmate answers yes to #4, have inmate change into suicide safe suit and place in the padded cell. Fill out mental health form and notify CRT.

Inmate Name Printed:_____

Inmate signature_____ Date:_____

Detention Officer signature:_____

Detention Officer Badge Number:_____ Date:_____

Effective Date: 01/15/2009

No Self Harm Contract

I_____ agree not to harm myself in any way from

_____ until _____.

If I have the urge to hurt myself, I will tell one of the Detention Officers or the Detention Nurse.

_____ _____

Witness Date Signature Date

_____

Printed Name

_____

Patient_____ refused to sign above contract.

_____ Date_____

CLASSIFICATION INTERVIEW QUESTIONS

(REVISED 05/98)

Inmate name: _____ Booking #: _____

Do you/have you use(d) any other names? _____

Current Address: _____ how long? _____

Charge(s): _____

Highest Grade Completed: 3 4 5 6 7 8 9 10 11 12 GED 1 2 3 4 +_____
Elementary/High School College

Can you read and write? _____

Do you have a job/were you a student before you entered the facility? Y N

Where do you work/go to school? _____

How long have you been Employed/attending School? _____

Do you have any health problems? _____

_____

Do you have trouble walking up or down stairs? _____

Do you have problems being around a large group of people? _____

Are you suicidal? Y N Have you ever attempted suicide? Y N How many times?_____

When was your last attempt? _____

Why did you attempt suicide? _____

Have you had any recent stressful experiences (i.e. loss of a loved one, divorce, loss of job, major health problem, serious financial problem, etc.)? _____

_____

Have you ever been diagnosed as having depression, manic, bi-polar, anxiety? _____

_____

Have you ever been to the mental health center, deac psych, warm springs, etc.? _____

_____

Why were you there? _____

Are you a member of any gang or radical group? _____

_____

Do you drink alcohol? _____ How often? _____

Do you use drugs? _____ What kind? _____

How often? _____

How many times have you been arrested? _____

Have you ever been convicted of a felony? _____

_____

Do you know of anyone at the facility with whom you may have problems? _____

_____

Have you read and understood the rules and regulations of the facility? Y N

Date: _____

Recommendations and comments: _____

_____

_____

_____

_____ _____

Classification Officer Inmates signature

INITIAL CUSTODY ASSESSMENT SCALE

I. IDENTIFICATION

Inmate Name (Last, First, MI) _____ Inmate Booking Number _____

Assessment Date _____ Classification Specialist _____

II. CUSTODY EVALUATION

1. SEVERITY OF CURRENT CHARGES/CONVICTIONS (Use Severity of Offense Scale; rate most serious charge/conviction, including any detainers/warrants)

Low	0	Score
Moderate	2	
High	5	
Highest	7	

2. SERIOUS OFFENSE HISTORY (Use Severity of Offense Scale; rate most serious prior conviction)

None or Low	0	Score
Moderate	1	
High	4	
Highest	7	

3. ESCAPE HISTORY (Excluding current charges)

No escape or attempts	0	Score
Walkaway or attempted escape from minimum security facility or failure to return from authorized absence	3	
Escape or attempted escape from medium or maximum security setting	7	

MAXIMUM CUSTODY SCORE (Add Items 1, 2, and 3) _____

SCORE OF 7 OR HIGHER, ASSIGN TO MAXIMUM CUSTODY . . . . . _____

(Always complete remaining items, but do not total score if inmate has already been assigned to maximum custody.)

4. INSTITUTIONAL DISCIPLINARY HISTORY

None or minor with no segregation time	0	Score
1 or more major disciplinary reports and/or time in segregation	3	

5. PRIOR FELONY CONVICTIONS (Excluding current charges)

None	0	Score
One	2	
Two or more	4	

6. ALCOHOL/DRUG ABUSE

No social, economic or legal problems related to abuse	0	Score
Abuse resulting in social, economic or legal problems	1	
Abuse resulting in assaultive behavior	3	

7. STABILITY FACTORS (Deduct indicated points)

Age 26 or over	-1	Score
Employed or attending school for 6 months prior to arrest	-1	
Lived at same address for 12 or more months prior to arrest	-1	

COMPREHENSIVE CUSTODY SCORE (Items 1-7) . . . . . _____ Total Score

III. SCALE SUMMARY AND RECOMMENDATIONS

A. CUSTODY LEVEL INDICATED BY SCALE. . . . . _____
1 - Minimum 2 - Medium 3 - Maximum Code

Custody Classification Chart

7 or more points on items 1-3	Maximum
5 or fewer points on items 1-7	Minimum
5 or fewer points on items 1-7 with detainer/warrant	Medium
6 to 10 points on items 1-7	Medium
11 or more points on items 1-7	Maximum

B. CHECK [X] ALL THE SPECIAL MANAGEMENT CONCERNS WHICH APPLY TO THIS INMATE:

_____ Protective Custody
_____ Psychological Impairment
_____ Mental Deficiency
_____ Escape Threat
_____ Serious Violence Threat
_____ Known Gang Affiliation
_____ Substance Abuse Problem
_____ Known Management Problem
_____ Suspected Drug Trafficker
_____ Suicide Risk
_____ Medical Problem
_____ Physical Impairment
_____ Other (specify): _____
Medical staff recommendation_____

C. OVERRIDE OF SCALE CUSTODY LEVEL IS RECOMMENDED . . . . . _____
1 - Yes 2 - No Code
If yes, give rationale (required): _____

_____

_____

D. RECOMMENDED CUSTODY LEVEL. . . . . _____
1 - Minimum 2 - Medium 3 - Maximum Code

E. Medical Staff signature (for override)_____

Specialist Signature _____ Date _____

IV. SUPERVISOR APPROVAL OF OVERRIDE

A. RECOMMENDED CUSTODY LEVEL. . . . . _____
1 - Approved 2 - Disapproved (Complete B.) Code

B. FINAL CUSTODY LEVEL (if override disapproved). . . . . _____
1 - Minimum 2 - Medium 3 - Maximum Code

Rationale (required if different from recommendation):_____

_____

_____

Supervisor Signature _____ Date _____

V. RECOMMENDED HOUSING ASSIGNMENT: _____